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ABSTRACT

This report discusses the success of desensitization techniques in alleviating specific anxiety but its failure in treating generalized anxiety. Anxiety management training (AMTO has been developed to overcome some of the deficiencies of desensitization approaches. Through the use of instructions and cues to arouse anxiety responses and the training of clients to develop competing responses such as relaxation, success, or competency, AMT provides the individual with a method for self-control appropriate to any anxiety provoking situation. Forty undergraduates referred by counseling centers participated in a study to assess the effectiveness of AMT. AMT was found to be effective in reducing both generalized and public speaking anxiety. A second paper presents the considerations involved in setting up a desensitization program in a counseling center. Areas covered include preparatory procedures, assessment of need, announcement of services, program operation, and follow-up and evaluation. (Author/LAA)

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THE USE OF ANXIETY MANAGEMENT TRAINING IN THE TREATMENT OF GENERALIZED AND SPECIFIC ANXIETIES[1]

John A. Nicoletti Jr.[2]

The effectiveness of systematic desensitization in the treatment of specific anxieties is a well established fact. Various approaches in the area of desensitization have been developed and all seem to be effective. These approaches have varied from individual treatment (Lang & Lazovik, 1963; Paul, 1966; Davidson, 1968) to group treatment (Lazarus, 1961; Emery & Krumboltz, 1968; Suinn, 1968; McManus, 1971) to the more innovative approaches such as short term desensitization (Suinn, Edie, Spinelli, 1970) and automated desensitization (Migler & Wolpe, 1967; Donner and Guerney, 1969; Suinn, Edie, Nicoletti & Spinelli, 1972).

In spite of the apparent effectiveness of systematic desensitization on specific anxieties, generalized anxiety has been difficult for behavior therapists and has been avoided as a treatment area. Generalized anxiety refers to anxiety in which there is no readily identifiable specific stimuli setting off the response. Lazarus (1963) indicated that Ss who exhibited pervasive anxiety received relatively lower percentages of success ratings and have the most unfavorable prognosis. Some researchers, in fact, feel that systematic desensitization is indicated only where specific

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anxiety rather than generalized or free-floating anxiety is present (Clark, 1963; Gelder, 1969). It appears that much of the difficulty in treating the more pervasive anxiety states centered around the difficulty in isolating the conditioned stimuli for anxiety. As a result of not being able to determine any specific anxiety stimuli, standard desensitization techniques have been ineffective because of their use of specific anxiety hierarchies.

Recently however, a breakthrough of a potential treatment has been made with the advent of a new technique called anxiety management training (Suinn & Richardson, 1971). Anxiety management training (AMT) is a non-specific behavior therapy approach which was developed to overcome some of the deficiencies in the standard desensitization approaches.

Basically, AMT involves: (1) the use of instructions and cues to arous anxiety responses, and (2) the training of the client in developing competing responses such as relaxation, or success or competency. This technique incorporates several important changes from the standard desensitization approaches, with the first difference being the lack of any specific hierarchy scenes. This variation is important in that, for the first time, it eliminates the necessity of relying upon specific stimulus conditions. By not having to

rely upon specific external stimuli AMT provides a unitary approach which could be used to treat all types of phobias or anxieties. With AMT the treatment of generalized anxiety is also possible because the technique has dispensed with the anxiety hierarchy and attempts to control the anxiety response itself.

The theory behind AMT, as set forth by Suinn and Richardson (1971), is based on the assumption that the anxiety or fear responses can themselves be viewed as discriminative stimuli and clients can be conditioned to respond to these stimuli with responses which effectively remove the stimuli through counterconditioning. Specifically, AMT utilizes relaxation or competency as responses to the stimulus anxiety cues.

AMT was first tested on subjects experiencing a specific anxiety related to mathematics. Results showed AMT to be effective in the alleviation of mathematics anxiety as measured by a math anxiety rating scale and an aptitude test. However, preliminary results of another investigation of the effectiveness of AMT with test anxiety (Richardson, 1971) did not show significant reductions as compared to a control group.

The purpose of the present study was to investigate the effectiveness of AMT in the treatment of generalized anxiety

and to add research on the effectiveness of AMT with a specific anxiety.

Method

Subjects. The Ss consisted of 40 undergraduate students attending either Colorado State University or Metropolitan State College who were referred by their respective counseling centers for either generalized anxiety or public speaking anxiety. Students selected for the generalized anxiety group were those who were experiencing a pervasive anxiety of a chronic nature not related to any known medical dysfunction and without any perceived specific or explicit causal factors. Students selected for the public speaking anxiety group were those who were experiencing specific anxiety centering around speaking in front of groups of people either formally or informally. After an initial interview Ss were assigned randomly to either a treatment or waitlist group for their respective anxiety, each group having ten members. A no-problem control group was also included (N=20).

Measures. The assessment instruments used in the study were the Taylor Manifest Anxiety Scale (Taylor, 1953); the IPAT Anxiety Scale (Cattell & Scheier, 1963); the Public Speaking Anxiety Inventory (Nicoletti, Edie, Spinelli, 1971); and the Anxiety Symptom Checklist (Edie, Nicoletti, Spinelli, 1972). All Ss were administered the four scales on two different occasions two weeks apart.

The Manifest Anxiety Scale (MAS) is a 50 item instrument developed to assess chronic anxiety. The scale itself consists of items which involve symptoms characteristic of anxiety neurosis. The IPAT is a 40 item questionnaire also designed to measure anxiety. The Public Speaking Anxiety Inventory is a 50 item scale developed to serve in the identification of public speaking anxiety and to measure changes in this anxiety. Each of the items on this scale involve a brief description of some event or situation relating to speaking that may evoke anxiety. The Anxiety Symptom Checklist is a scale designed to measure various symptoms experienced by people who report tension. The scale was developed on the assumption that when people report that they are "feeling" anxious or tense, they are responding to various changes or states in the autonomic or central nervous system. The scale consists of 40 symptoms related to anxiety and is broken down into three dimensions of anxiety: frequency, intensity and interference.

Treatment Procedure. Treatment consisted of five sessions of approximately two hours each and was conducted in groups of approximately seven to nine students.

During the first treatment session all the Ss were given an outline explaining the goals of each treatment session along with a brief verbal overview. The overview attempted

to communicate to the Ss the fact that anxiety was a learned response capable of being modified and the purpose of AMT was to provide a more adaptive alternative to the anxiety response. Following the brief introduction the Ss were administered the scales in the specified order. After the last scale was completed the Ss were trained in relaxation as described by Wolpe and Lazarus (1966). At the end of the relaxation training the Ss were given the instructional set to practice the relaxation as much as possible. The Ss were then given the opportunity to ask any questions and respond to the relaxation.

The next three sessions involved the use of AMT, i.e., the application of relaxation technique for anxiety control. The basic procedures for these three sessions involved first of all relaxing the Ss then inducing anxiety by guiding them through various synptoms associated with anxiety. The Ss were then instructed to control the anxiety by using the deep breath as a cue to relaxation. This process of relaxation-anxiety induction-anxiety control was completed three times in each session. However, as the sessions progressed the therapist's instructions during anxiety control were gradually decreased in order to encourage the Ss to assume more control themselves.

Session five was the termination session and involved posttesting the Ss on all scales in the specified order and interviewing them again.

The AMT approach used in this study differed from the original AMT approach in that it had four procedural changes:

1. The utilization of a control cue--deep breathing;
2. The emphasis upon physiological cues rather than scene visualization;
3. The addition of two more session;
4. The elimination of the automated segment.

Results

Pretest and posttest scores for the IPAT, MAS, PSI and ASCL were obtained for all Ss. Analysis of variance and analysis of covariance designs were used in analyzing the data.

AMT with Generalized Anxiety. The mean pretest and posttest scores and standard deviation on each scale for the generalized anxiety treatment group (GAT), the generalized anxiety waitlist group (GAW) and the no-problem control group (NPC) appear in Table 1.

TABLE 1

Statistical comparisons between the GAT and GAW indicated no significant differences between the two groups on the pretest scores for all the scales (MAS F=0.831; IPAT F=0.516; ASCL F=0.020; PSI F=0.230). Comparisons between the two groups on the posttest scores indicated a signigicant difference on the MAS (F=18.718), IPAT (F=4.471), and PSI (F=4.982) but not on the ASCL (F=3.493). However, subscale analysis of the ASCL indicated a significant difference between the GAT and GAW on frequency (F=7.698) and intensity (F=5.426) but not on interference (F=2.622). Posttest comparisons between the GAT and NPC indicated that the treatment group dropped as low as the no-problem group on the MAS (F=2.445) but not on the IPAT (F=12.024) and the ASCL (F=11.830).

AMT with Public Speaking Anxiety. The mean pretest and posttest scores and standard deviations on each scale for the public speaking anxiety treatment group (PST), the public speaking anxiety waitlist (PSW) and the no-problem control group (NPA) appear in Table 2.

TABLE 2

Statistical comparisons were made for the public speaking anxiety people only on the specific public speaking anxiety scale since the Ss did not score higher than the NPC on the general anxiety scales. Results of the pretest analysis on the PSI indicated no significant difference between the PST and PSW ($F=1.596$). Results of the posttest analysis indicated a significant difference between the PST and PSW ($F=10.660$) and no significant difference between the PST and the NPC ($F=0.0368$).

Discussion

Results of the study seem to support the hypotheses that AMT is effective in reducing both generalized anxiety and public speaking anxiety when compared to waitlist controls in a college population. For the generalized anxiety Ss the effectiveness of AMT centers around decreasing the frequency and intensity of the anxiety symptoms, but the amount of interference caused by the symptom occurrence is not changed. The decrease in anxiety experienced by the GAT, although significantly lower than the GAW, was not large enough to bring them to the level of a no-problem group on all the scales.

Results of the comparison between the PST and PSW showed that AMT was significant in reducing public speaking anxiety.

The results of AMT with this specific anxiety are consistent with the study by Suinn and Richardson (1971) in which they found AMT to be effective with a specific anxiety centering around mathematics.

The results of the present study are important in that they are supportive of a technique which is a step in the direction of providing the individual with a method for self control. This form of self control could be appropriate in any anxiety provoking situation regardless of the particular stimulus conditions.

Even though AMT has proven to be an effective technique in controlling anxiety, there are some considerations whic must be taken into account. The technique of deliberately inducing anxiety in an already anxious person should be done with utmost consideration for possible problems. For example, two female Ss in the present study reached such an intense level of anxiety that they began to cry and shake. Fortunately, however, both Ss were able to shut off the anxiety and return to a relaxed state. If a generalized anxiety population is treated, it would seem beneficial to have the therapist aware of the difficulties and trained to handle them.

An interesting indirect result of treating generalized

anxiety with AMT is the expression of other feelings besides anxiety and relaxation by the Ss after the treatment sessions. Some of the other feelings reported have centered around anger, sen and insecurity. One possible explanation for the expression of other feelings could center around the fact that anxiety was reduced which made possible the expression of some less acceptable feelings.

The possibilities for AMT are far reaching and it is conceivable that it could be incorporated into many mental health programs as an ongoing technique. The technique, however, should be more extensively researched and should be looked at as one approach for controlling anxiety which could be used as the sole treatment or in conjunction with another approach.

FOOTNOTE

[1]Paper presented at American Psychological Association meeting September, 1972.

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TABLE 1

Pretest and Posttest Mean Scores and Standard Deviations for GAT, GAW and NPC on the IPAT, MAS, ASCL and PSI

		Pretest		Posttest	
Group	Scales	Mean	S.D.	Mean	S.D.
GAT	IPAT	47.20	9.58	40.00	10.01
	MAS	32.20	7.39	23.30	7.78
	ASCL	291.00	68.84	250.50	62.65
	PSI	160.10	33.34	135.50	36.89
GAW	IPAT	50.60	11.50	48.70	13.60
	MAS	31.40	10.30	33.20	9.73
	ASCL	296.00	88.89	291.60	98.04
	PSI	168.50	44.13	164.00	45.12
NPC	IPAT	35.70	10.26	35.35	9.70
	MAS	20.95	7.67	18.90	7.01
	ASCL	201.15	32.88	192.10	35.13
	PSI	149.35	18.93	138.55	24.90

TABLE 2

Pretest and Posttest Mean Scores and Standard Deviations for PST, PSW and NPC on the IPAT, MAS, ASCL and PSI

		Pretest		Posttest	
Group	Scales	Mean	S.D.	Mean	S.D.
PST	IPAT	37.00	26.94	29.80	11.4
	MAS	22.70	5.26	17.70	7.70
	ASCL	230.30	45.27	204.50	50.84
	PSI	176.40	23.95	136.50	30.38
PSW	IPAT	35.00	12.68	36.30	12.61
	MAS	18.90	7.79	19.10	8.81
	ASCL	197.10	39.01	199.60	47.13
	PSI	159.50	30.61	148.20	33.13
NPC	IPAT	35.70	10.26	35.35	9.70
	MAS	20.95	7.67	18.90	7.01
	ASCL	201.15	32.88	192.10	35.13
	PSI	149.35	18.93	138.55	24.90

CONSIDERATIONS IN SETTING UP A FULL SERVICE DESENSITIZATION PROGRAM[1]

JOHN A. NICOLETTI JR.[2]

The literature in desensitization contains numerous studies showing the effectiveness of the technique in alleviating various anxiety problems. However, todate, little research is available on the procedures and considerations involved in setting up an ongoing desensitization program. The purpose of the present paper, therefore, is to provide some input into the factors and steps involved in setting up an ongoing desensitization program within the context of an actual counseling center environment. Most of the information presented in the paper has resulted from setting up such a program in the counseling center at Colorado State University. The main steps involved in setting up a desensitization program are: (1) preparatory procedures, (2) assessing the need, (3) announcement of availability of service, (4) meeting the need, and (5) follow-up and evaluation.

Preparatory Procedures

Preparation procedures involves basically preparing the staff through selling them on the idea of desensitization and providing them training in the area. Selling the staff does not neanssarily mean that all the staff at a center must use desensitization techniques, but it does mean that they should at least view the approach as valid. The staff must view

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the technique as valid in order to get referrals to the program. Much of the staffs' reactions to the desensitization approaches are going to depend upon their previous experiences with the techniwue along with the way it is presented to them. Presenting desensitization as one viable approach among many other useful techniques is more likely to gain supporters than presenting desensitization as the only technique to be used.

Training for the staff should center around problem identification and acquisition of technique skills. Problem identification is important in referral procedures. The counselors must know what problems are appropriate for desensitization before they can make accurate referrals. A working knowledge of the techniques is necessary if the individual counselor would like to utilize desensitization in his own treatment repertoire.

Assessing The Need

Assessing the need involves finding out what problems are present in the particular treatment setting that can be handled most effectively by desensitization procedures. Personal experience is the most practical way to assess the need. This involves having the counselors survey the people who have requested service at their center and select those areas that can be treated by desensitization. Some of the more common areas that can be treated by desensitization in

a counseling center environment are: academic anxieties, social anxieties, public speaking anxiety, and generalized anxiety.

A second method for assessing the needs involve contacting the college population through a survey. This second approach will give data on the problems that might be present but have not necessarily reached the counseling center such as various minor phobias like spiders and snake fears. Whatever approach the counseling center takes in assessing the needs it is important that they develop programs which are relevant to the problems present.

Announcement of Availability of Service

In the program developed at Colorado State University's counseling center three main resources were utilized in announcing services the student newspaper, the university faculty and the university staff. Announcements of services articles were placed in the student newspaper usually at the beginning and end of the academic quarters. The articles indicated the type of services available, where it is being offered and who to contact. Similar notices were also sent periodically to the faculty and staff of the university. Included in the circulations were such people as advisors, dorm counselors, and deans of students. The student advisors were found to be very helpful in identifying problems and referring students to the couhseling center. Another referral

source which proved to be particularly beneficial was word of mouth. This involved the student who had been treated at the center recommending the programs to their friends, roommates and others. However, this source of referral really did not occur until at the end of the first quarter of program operation.

Meeting the Need

Once the needs of the students have been assessed and the services announced, the counseling center is then faced with meeting the demand for the services. Possibly the new demand could be met by the existing personnel if it is not too great. However, it seems that once a service is made available the demand for that service significantly increases. Two ways in which an increase in demand can be met are by either increasing personnel or utilizing technique refinements

Expanding personnel can be accomplished by either hiring more professionals or training paraprofessionals. The utilization of paraprofessionals is one area that has gained widespread support in the past few years. Paraprofessional help was used in all phases of the desensitization program at Colorado State Universiy. They were used in intake evaluation, treatment and follow-up. Training was accomplished through both didactic and experientaal approaches.

The second approach available to meet an increased demand for services is the use of technique refinements. For example, the use of group desensitization as opposed to individual desensitization is an example of a refinement that has been proven effective. Group desensitization allows more clients to be seen at the same time and conserves on the counselors time. Other effective refinements that can be used are automated techniques, accelerated techniques and massed techniques. A more recent approach is the development of anxiety manggement training (AMT) which enables multiple anxieties to be treated at the same time.

Follow-up and Evaluation

A final but necessary step in the development of a full service desensitization program is the follow-up of the clients and evaluation of the program's effectiveness. The programs should be evaluated in terms of their appropriateness and their effectiveness. An effective program that is not needed is just as useless as a needed but ineffective program. Both factors must be considered. Program effectiveness can be assessed through either objective or subjective scales. There are numerous objective scales available to assess problems such as test anxiety, public speaking anxiety, generalized anxiety, etc. Selection of these scales However, is really determined by the institution's particular needs. In addition, the center can go the

route of developing and standardizing their own scales if the ones available are not relevant. Another important way of evaluating the effectiveness of the program is by client feedback, which after all is what determines if a technique has worked.

Conclusion

In summary, an ongoing desensitization program is not the only approach that should be present in a full service counseling center, but it can be a useful tool along with the other approaches. Desensitization should be used where it can be appropriate. It is also important that we as counselors not overlook the fact we are still working with people and it is important to exhibit the variables that are necessary in any therapeutic relatuionship such as empathy, respect and warmth.

FOOTNOTE

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